Alaska Medicaid

**BISPHOSPHONATES Oral Formulation**
Actonel® (all strengths), Atelvia®, Binosto® Eff, Boniva®, Fosamax + D

**Criteria for Approval:**

- Coverage will be given for Alendronate sodium (5mg, 10mg, 35mg, 40mg, 70mg)
- Coverage will be given to Actonel, Atelvia, ibandronate (generic Boniva), or Fosamax + D if the recipient has completed a minimum of 30 day trial or documentation of adverse reaction to alendronate
  - For Binosto, please submit additional documentation supporting use of effervescent dose form over tablet formulation
- If alendronate trial is not an option, please submit medical rationale and letter of medical necessity

**Length of Authorization:**

- Coverage may be approved for 1 year.

**Dispensing Limit:**

- The dispensing limit is a 30 day supply of medication

**Reminder:** You are encouraged to report negative side effects of prescription drugs to the FDA. Visit [http://www.fda.gov/Safety/MedWatch/default.htm](http://www.fda.gov/Safety/MedWatch/default.htm) or call 1-800-FDA-1088